



Medicare
Payment Advisory
Commission

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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT ON MEDICARE PAYMENT POLICY

Washington, DC, June 15, 2006—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2006 *Report to the Congress: Increasing the value of Medicare*. The report examines new directions to increase the value of the Medicare program: increasing accountability and care coordination, providing better information and the tools to use it, and improving pricing accuracy.

Improving accountability and care coordination. Providers must be held accountable for the quality of care they provide and the resources consumed in providing that care. Quality pay-for-performance programs are the first step. The next step toward improving accountability is measuring physician resource use. The report examines one method to achieve this—episode groupers. It finds that the two groupers tested generally agree on the number of episodes created and the types of services in episodes, and that resource use and quality vary for certain conditions across the 13 metropolitan statistical areas tested. MedPAC plans to examine linking episodes and quality to individual physicians.

Care coordination has the potential to improve value in the Medicare program. Even if individual providers deliver high quality, efficient care, overall care for a beneficiary may be sub-optimal if providers do not coordinate across settings or assist beneficiaries in managing their conditions between visits. The report outlines two illustrative models of integrating care coordination into fee-for-service Medicare for beneficiaries with chronic conditions: one using group practices to furnish care coordination services and another using stand-alone care management organizations. In both models organizations would be required to have information technology and care manager capacities and would agree initially to cost savings as a condition of payment. Incentives for physicians are also discussed.

Private plans in Medicare. The biggest change in Medicare in recent years is the advent of the prescription drug benefit. The report finds nearly 80 organizations are offering 1,429 stand-alone drug plans across the country. More than 20 stand-alone plans are available to beneficiaries in every region of the country. Plan premiums vary, but in almost every region beneficiaries have access to coverage for a premium of less than \$20 per month. There are also 1,303 Medicare Advantage (MA) plans with drug coverage. They tend to charge lower premiums for Part D coverage (nearly 40 percent charge nothing), but beneficiaries must agree to receive all of their Medicare benefits from these plans to take advantage of the lower cost for Part D coverage. There are clear patterns in benefit design, for example 66 percent of private drug plan offerings and 83 percent of MA drug offerings have no deductible or a reduced deductible, and more than 90 percent of all drug plans use tiered formularies with copayments. Plans usually apply at least some drug utilization tools—such as prior authorization, step therapy, and quantity limits—to selected drugs. Plans use these tools for drugs that are expensive, potentially risky, subject to abuse, or to encourage use of lower cost therapies.

The report also discusses how Medicare beneficiaries learned about the Medicare drug benefit and made choices. For example, those who signed up for the benefit reported doing so to save money on current drug

costs and protect themselves against future drug costs. Beneficiaries who had enrolled or were considering enrolling in a plan spent considerable time studying their options and found the large number of choices available to them confusing, but a majority said they had enough information to make a decision.

Medicare beneficiaries have more MA plans to choose from in 2006 than ever before. Most of those plans have both low premiums and enhanced benefits. Specific findings for 2006 include: 99.6 percent of beneficiaries have MA plans available to them, zero-premium MA plans are available to 86 percent of beneficiaries, and almost three-quarters of beneficiaries have access to zero-premium plans that also include the Part D benefit. In addition, 276 special needs plans are available and private fee-for-service plans are available to 80 percent of beneficiaries, an increase from 45 percent in 2005.

Providing better information and the tools to use it. Medicare policymakers and administrators need better information both to formulate policies and to create tools to give useful information to beneficiaries and providers. Providers need better information to assure quality care and limit unnecessary resource use; beneficiaries need information to maintain a healthy lifestyle and to choose the highest quality care at lowest cost.

- The report identifies best practices related to fall prevention and wound care that would help improve the quality of care in home health agencies. The Commission urges CMS to develop and test related measures and to add them to home health's measure set.
- The report urges CMS to collect better information about the outpatient therapy needs of beneficiaries and their outcomes. Specifically, CMS will need to develop patient assessment tools that report risk factor information and outcomes measures. This would help evaluate alternative payment methods that could increase the value of the therapy services Medicare purchases
- A pressing issue for Medicare is that technology diffuses rapidly without sufficient analysis or guidelines that target its use to the patients who will benefit the most. The report considers how results from cost-effectiveness studies for the same service vary and illustrates that there are both opportunities and challenges in using cost-effectiveness studies in Medicare. The Commission plans to explore ways to develop an infrastructure to systematically develop information on both the clinical and cost effectiveness of a service and ways Medicare can use this information.

Improving the accuracy of prices. The prices Medicare pays for individual services may not be accurate. The report considers how to improve payment accuracy in two sectors:

- The report finds that adding case-mix adjusters to the number of days in the current hospice service payment categories did not improve the ability to predict variation in labor costs. Payment accuracy might be improved by paying more for the first and last days of the hospice stay than for the intervening days. However, more detailed data from hospice agencies on the cost of services, the services provided, and the characteristics of the patients served are needed to reach definitive conclusions.
- The report reviews the data sources that CMS uses to derive practice expense payments in the physician fee schedule. The current data are outdated and the Congress should provide CMS with the financial resources and administrative flexibility to collect new data and compute practice expenses. To improve the accuracy of payment for equipment, CMS could revisit its assumption that equipment is operated 50 percent of the time. Our analysis of the use of magnetic resonance imaging (MRI) machines and computed tomography (CT) machines suggests that assumption may be too low.

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The Medicare Payment Advisory Commission is an independent Congressional advisory body charged with providing policy analysis and advice concerning the Medicare program and other aspects of the health care system. Its 17 commissioners represent diverse points of view and include health care providers; payers; beneficiary representatives; employers; and individuals with expertise in biomedical, health services, health economics research, and prescription drug benefit programs.